



TRI-REGIONAL BLIND-LOW VISION EARLY INTERVENTION PROGRAM
REFERRAL FORM

CLIENT AND CONTACT INFORMATION

Form section for Client and Contact Information with fields for Child's Name, Gender, DOB, Parent/Guardian, Relationship to child, Tel (H), Tel (C), Address, Town/City, and P.C.

PARENT/GUARDIAN INFORMATION

REFERRAL INFORMATION

Form section for Parent/Guardian and Referral Information with fields for Name of Parent/Guardian Primary Contact, Name of Person Making Referral, Address, Title, Town, PC, Organization, Tel (H), Tel (C), and Relationship to child.

VISION INFORMATION

Form section for Vision Information with fields for Cause of visual impairment, Additional ocular diagnosis, Cortical/Cerebral visual impairment (CVI), CVI Suspected, N/A, Does the child have an ophthalmologist?, If yes, Name, Agency, and Other Diagnoses (if known).

All children aged birth to school entry with a visual impairment are eligible for service in Ontario.

Eligibility: A child is eligible for the services if one or more of the following exists:

- Checkboxes for eligibility criteria: A potential visual acuity of no better than 20/70, Visual field restrictions to 20 degrees or less, and Reduced visual abilities due to neurological issues.

Referrals can be made by anyone; however the presence of one or more of the conditions listed above must be confirmed by an ophthalmologist.

How to Refer

Fax completed referral form to:

Child Development Programs, Blind Low Vision Early Intervention Program
Fax: 905-472-7553

Mail completed referral form to:

Child Development Programs, Blind Low Vision Early Intervention Program
Markham Stouffville Hospital, 379 Church St., Suite 309, Markham, ON L6B 0T1

Contact us directly at: 905-472-7373 x 6451 or Central Intake: 1-888-703-KIDS to make the referral over the telephone.

